Deputy Sheriff
Booklet 2

Regence BlueShield Medical/Vision

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Table of Contents: Regence BlueShield Medical/Vision

Overview

► Highlights of Regence BlueShield Coverage

This summary of benefits available under this plan was prepared by King County. For complete details on benefits, please refer to the Regence BlueShield brochure (contact Regence BlueShield; see the Resource Directory booklet).

Here are a few highlights of your coverage under the Regence BlueShield plan:
- You pay an annual deductible before the plan pays for most benefits, then the plan pays 80%-100% for most services
- The plan offers a wide choice of approved providers (see "Approved Service Area Providers" and "Approved Out-of-Area Providers").

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:
- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

The county pays the full monthly cost of coverage for you and eligible family members you enroll under this plan.

When you receive medical care, you pay:
- The annual deductible (when applicable)
- Coinsurance amounts not covered by the plan
- Copays for emergency room care (waived if admitted) and prescription drugs
- Amounts in excess of allowed amounts (as determined by Regence BlueShield)
- Expenses for services or supplies not covered by the plan.

See "How the Plan Works" and "Covered Expenses Under Regence BlueShield" for details on deductible, coinsurance and copay amounts.

Preexisting Condition Limit

This plan does not have a preexisting condition limit.

If you end employment with King County, please refer to "Certificate of Coverage" in this booklet for information on how your participation in this plan can be credited against another plan with a preexisting condition limit.

How the Plan Works

► Plan Features

The following table identifies some plan features, including your out-of-pocket maximum and how benefits are determined for most covered expenses. The sections after the table contain more details.

Plan Feature	Regence BlueShield
Provider choice	You must use Regence BlueShield and recognized providers (described below) for all covered services received within the service area (except emergency care) and may use any approved provider for covered services outside the service area (also see "Accessing Care")
Annual deductible	$100/person, $300/family Deductible doesn't apply to accidental injury care, prescription drugs, second surgical opinions, vision care or occupational injuries (LEOFF 1 only)
Copays	For emergency room care and prescription drugs (see "Summary of Covered Expenses" for amounts)
After the copays, the plan pays most covered services at this level ...	80%-100% of the allowed amount
Until you reach your annual out-of-pocket maximum...	$375/person (excluding deductible and copays)
Then, most benefits are paid for the rest of the calendar year at ...	100%
Lifetime maximum	$1,000,000/person

► Approved Service Area Providers

The providers listed in this section are all approved providers when you receive their services within the Regence BlueShield service area. For more about how benefits are paid when you see these providers, see "Accessing Care."

Regence BlueShield (Participating) Providers. These are participating providers (hospitals, clinics, doctors and other health professionals) that have agreements with Regence BlueShield to provide services within its service area. When you receive services from one of these providers, benefits are paid as described in "Covered Expenses Under Regence BlueShield," based on the allowed amount, and the provider files your claim

You must use these providers for care within the service area (except for emergency care).

For a list of Regence BlueShield providers and service area information, contact Regence BlueShield (see the Resource Directory booklet).

Recognized Providers. These are providers within the service area that do not have participating agreements with Regence BlueShield, but act within the scope of their licenses to provide specific benefits described in "Covered Expenses Under Regence BlueShield" (for example, ambulance and blood bank services). When you receive services from a recognized provider, benefits are paid at the level shown in "Covered Expenses Under Regence BlueShield," based on allowed amounts.

Emergency Care Providers. You may see any provider within the service area for emergency care. For emergency care from a non-Regence BlueShield provider, benefits are paid for 24 hours or until you can reasonably be transferred to a Regence BlueShield provider. Benefits are based on the non-Regence BlueShield provider's actual charges, which must be reasonable and not increased because of plan coverage.

► Approved Out-of-Area Providers

The providers listed in this section are all approved providers when you receive their services outside the Regence BlueShield service area. For more about how benefits are paid when you see these providers, see "Accessing Care."

BlueShield and/or Blue Cross (Participating) Providers. These are participating providers (hospitals, clinics, doctors and other health professionals) that have agreements with other Blue Shield and/or Blue Cross organizations outside the Regence BlueShield service area. When you receive services from one of these providers, benefits are paid as described in "Covered Expenses Under Regence BlueShield," based on allowed amounts, and the provider files your claim.

For a list of these providers, contact Regence BlueShield (see the Resource Directory booklet).

Non-Participating Providers. These are providers (hospitals, clinics, doctors and other health professionals) outside the service area that do not have participating agreements with Blue Shield or Blue Cross organizations, but are qualified under plan benefits. When you receive services from one of these providers, benefits are paid as described in "Covered Expenses Under Regence BlueShield," based on allowed amounts. If the provider charges more than the allowed amounts, you pay the difference (your share of the total cost is higher).

Emergency Care Providers. You may see any provider outside the service area for emergency care. For emergency care from a non-participating provider, benefits are paid for 24 hours or until you can reasonably be transferred to a participating provider. Benefits are based on the non-participating provider's actual charges, which must be reasonable and not increased because of plan coverage.

► Annual Deductible

The annual deductible is the amount you must pay each year toward covered benefits before the plan starts paying. The annual deductible is $100 per person to a maximum of $300 for a family. Any amount you pay toward your deductible during the last three months of any calendar year applies toward next year's deductible. If:

- Three or more family members incur $300 in eligible deductible expenses, you meet the family deductible (no further deductible is required from any family member for the rest of that year)
- Two or more family members are in the same accident, only one individual deductible applies to any charges incurred in that and the next calendar year as a result of the accident
- Your hospitalization continues from one calendar year to the next, a second deductible is not required for any treatment received before your discharge from the hospital (additional coinsurance isn't required if you've met your out-of-pocket maximum for the calendar year in which the hospitalization began; see "Annual Out-of-Pocket Maximum" below).

The annual deductible does not apply to accidental injury care, prescription drugs, vision care, occupational injuries for LEOFF 1 or properly obtained second surgical opinions.

► Annual Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay in coinsurance for covered expenses each plan year. This means once you reach your out-of-pocket maximum, the plan pays 100% of most covered expenses for the rest of the calendar year.

Your annual out-of-pocket maximum is $375 per person. The following do not apply to the out-of-pocket maximum:

- Annual deductible
- Charges in excess of allowed amounts
- Charges beyond benefit maximums and limits
- Copays for emergency room care or prescription drugs
- Expenses not covered by the plan

- Services for:
  - Neurodevelopmental therapy
  - Outpatient mental health care
  - Outpatient rehabilitation
  - Smoking cessation
  - Tooth repair
- The amount you pay for inpatient care outside the service area from a non-participating provider if it's not approved by Regence BlueShield
- The amount you pay if you're a LEOFF 2 member and:
  - Certain surgeries are performed on an inpatient basis (see "Mandatory Outpatient Surgery for LEOFF 2 Members Only")
  - You don't obtain a mandatory second surgical opinion (see "Mandatory Second Surgical Opinions for LEOFF 2 Members Only").

► Lifetime Maximum

The total amount paid for all benefits under this plan is limited to a lifetime maximum of $1,000,000. Up to $20,000 of this maximum is restored automatically at the start of each year for benefits paid during the previous year.

Some individual benefits have lifetime maximums (see "Covered Expenses Under Regence BlueShield" for details):
- Occupational injury – combined lifetime maximum of $250,000 (employee only)
- Smoking cessation – $500
- Transplants – $250,000.

► Accessing Care

Generally, to receive benefits, you:
- Make an appointment with a:
  - Regence BlueShield provider within the service area (see "Approved Service Area Providers") or
  - Any qualified provider outside the service area (see "Approved Out-of-Area Providers")
- Present your Regence BlueShield ID card to your provider before receiving services (remind your provider to submit your claim with the three-digit alpha prefix that's in front of your member ID number).

For emergency care, you may see any provider. If you receive emergency care from a non-participating provider outside the service area, contact Regence BlueShield within 48 hours.

Participating Providers. When you see participating providers, benefits are paid as described in "Covered Expenses Under Regence BlueShield," based on allowed amounts, and the provider files your claim. You pay the applicable copay to the provider when you receive services; Regence BlueShield processes the claim and provides you with an Explanation of Benefits. The EOB shows any additional amount you must pay the provider, based on the allowed amount, annual deductible and annual out-of-pocket maximum.

When you receive services from a participating provider outside the U.S. or its territories, follow these steps:
- For emergency medical care, go to the nearest hospital and show your Regence BlueShield ID card. If you're admitted, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 804-673-1177 (services are available 24 hours a day, seven days a week).
- For non-emergency medical care, call the BlueCard Worldwide Service Center to arrange your hospitalization if necessary at a BlueCard Worldwide hospital or make an appointment with a physician.

You're responsible for out-of-pocket expenses such as any applicable deductible, copays, coinsurance and non-covered services for your inpatient care. For outpatient, hospital care or professional services, you're responsible for paying the hospital or physician at the time of service; then complete an international claim form and send it to

the BlueCard Worldwide Service Center for reimbursement of covered services. International claim forms and more information about BlueCard Worldwide are available at www.bcbs.com.

Non-Participating Providers. When you see a non-participating provider outside the service area, benefits are paid at the level shown in "Covered Expenses Under Regence BlueShield," based on allowed amounts. You may be required to pay the provider in full and file a claim for reimbursement, or the provider may file the claim for you. Either way, Regence BlueShield processes the claim and provides you with an EOB.

The EOB shows any amount you must pay the provider (if not already paid), based on the allowed amount, annual deductible, annual out-of-pocket maximum and any charges above the allowed amount. If the provider charges more than the allowed amount, you pay the difference (your share of the total cost is higher).

Emergency Care Providers. You may see any provider for emergency care. When you receive emergency care from a non-participating provider, benefits are based on the provider's actual charges for 24 hours or until you can reasonably be transferred to a participating provider. The charges must be reasonable and not increased because of plan coverage.

► Obtaining Preadmission Approval for Inpatient Care Outside the Service Area

Preadmission approval is required if you seek inpatient care from a non-participating provider outside the service area; it is not required for emergency care or maternity admissions. All medical and surgical care received outside the service area (except emergency and maternity) must outpatient, unless Regence BlueShield determines inpatient care is medically necessary. (If you receive inpatient emergency or maternity care from a non-participating provider outside the service area, contact Regence BlueShield within 48 hours; see "Emergency Care" and "Maternity and Women's Health Care.")

When you seek non-emergency inpatient care from a non-participating provider outside the service area, the provider must contact Regence BlueShield by phone or submit a Preadmission Review Request form to the plan at least 10 days before your admission date (the form is available from Regence BlueShield; see the Resource Directory booklet). Regence BlueShield evaluates the information provided by your provider to determine if inpatient care is medically necessary.

If preadmission approval is not requested or Regence BlueShield determines inpatient care is not medically necessary, inpatient benefits, including any related physician's services, are paid at 50% or the amount that would have been paid for services received in an appropriate alternative setting, whichever is greater.

You'll need a new approval for each admission or readmission. If approval is not obtained, Regence BlueShield will determine if inpatient care was medically necessary when the claim is submitted.

► Mandatory Outpatient Surgery for LEOFF 2 Members Only

The following medical and surgical procedures usually don't require inpatient treatment and must be outpatient (such as in an ambulatory surgical center, physician's office or hospital outpatient facility), unless Regence BlueShield determines inpatient care in a hospital or skilled nursing facility is medically necessary:

- Arthroscopy (instrumental examination of a joint); arthroscopic surgery of the knee
- Biopsy and excision of lesions that are readily accessible and can be done with local or topical anesthesia (such as skin, oral cavity, vagina, recto-sigmoid)
- Cataract extraction not complicated by serious medical conditions
- Diagnostic dilation and curettage – not in conjunction with major surgery, pregnancy or hemorrhage
- Endoscopic procedures (instrumental examinations) that are uncomplicated, do not require a general anesthetic and are not in conjunction with major surgery, including laryngoscopy, bronchoscopy, esophagoscopy, proctosigmoidoscopy and colonoscopy
- Foot surgery confined to one foot and not complicated by serious medical conditions
- Genito-urinary system procedures unless in conjunction with major surgery or complicating conditions
- Incision and drainage of uncomplicated abscesses and cysts including myringotomy (incision of the ear drum)

- Surgical sterilization (vasectomy and laparoscopic tubal ligation) unless in conjunction with major procedures or complicating conditions
- Tonsillectomy and/or adenoidectomy under age 12
- Uncomplicated nasal surgery such as surgery for nasal polyps or deviated septum.

When these procedures are performed on an outpatient basis or Regence BlueShield determines inpatient care is medically necessary, payment is at the full benefit level of the plan. If these procedures are performed on an inpatient basis without Regence BlueShield approval, payment, including payment for related professional services, is at 50% of the plan's allowed amount.

Benefits for the procedures listed are subject to the annual deductible and any other plan provisions.

► Mandatory Second Surgical Opinions for LEOFF 2 Members Only

A second physician's opinion for the surgeries listed below is required to receive the full benefit level. The second opinions are not subject to the annual deductible when requested according by the procedures described in this section.

The physician's services and any related x-ray and lab charges for the second opinion are covered in full. If the second opinion isn't obtained, benefits are 50% of the allowed amount for all covered professional services relating to the surgery, including but not limited to the surgeon's charges (hospital charges are not subject to the 50% reduction).

- Bunionectomy
- Cholecystectomy
- Coronary bypass
- Dilation and curettage
- Excision of cataracts
- Hemorrhoidectomy
- Hysterectomy
- Inguinal hernia repair
- Knee surgery
- Laminectomy or spinal fusion
- Mastectomy
- Prostatectomy
- Rhino-/septoplasty
- Tonsillectomy and/or adenoidectomy
- Varicose vein stripping and ligation.

The second opinion is required only if the surgical procedure is a non-emergency, meaning it can be scheduled at the patient's convenience without jeopardizing life or causing serious impairment of bodily functions. If the patient lives outside the service area, the second opinion requirement is waived.

Participating providers can obtain a second opinion referral by contacting Regence BlueShield. The second opinion must be obtained from a physician referred by Regence BlueShield who will not be performing the surgery. After the second opinion is received, benefits are provided if the surgery is performed within six months of the second opinion.

If second opinion procedures aren't followed, benefits for the opinion and any related charges are based on the allowed amounts and subject to the annual deductible.

A third opinion is covered if the first two opinions do not agree, but no additional opinions are covered. Once you receive the second opinion, even if the physicians don't agree, the decision to have the surgery rests with you.

► Voluntary Second Surgical Opinions for LEOFF 1

If you choose to get a second opinion before having surgery, the physician's services and any related x-ray and lab charges are paid in full for the second opinion. They're not subject to the annual deductible when performed by the physician referred to you as described in this section.

Your participating physician can obtain a second opinion referral by contacting Regence BlueShield. The second opinion must be obtained from a physician referred by Regence BlueShield who will not be performing the surgery.

If you don't follow the second opinion procedures, benefits will be paid at the payment level described for "Professional Services" in the "Summary of Covered Expenses" section, subject to the deductible.

A third opinion is covered if the first two opinions do not agree, but no additional opinions are covered. Once you receive the second opinion, even if the physicians don't agree, the decision to have the surgery rests with you.

► Individual Benefits Management

For certain illnesses or injuries, Regence BlueShield Individual Benefits Management staff work with you and your provider to determine the most cost-effective, beneficial treatment options for your specific case. In some instances, the Individual Benefits Management staff may preauthorize benefits that wouldn't normally be covered under this plan. The final decision on the course of treatment rests with you and your provider.

When provided at equal or lesser cost, benefits are available for home health care instead of hospitalization or other inpatient care by a licensed home care agency or by a home health or hospice agency covered under this plan. Substitution of less expensive or less intensive services can be made only with your consent and when recommended by your physician or other provider, based on your medical needs. Regence BlueShield may require a written treatment plan.

Coverage is limited to the plan maximum payable for hospital or other inpatient expenses, subject to any applicable deductible, coinsurance and plan limits. These benefits are provided only when your condition is serious enough to require inpatient care and you could qualify for the inpatient benefits of this plan; custodial care is not covered.

Covered Expenses Under Regence BlueShield

► Summary of Covered Expenses

The following table summarizes covered services and supplies under this plan (only medically necessary services and supplies are covered) and identifies related coinsurance, copays, maximums and limits. For more details, see the sections after the table as well as "Expenses Not Covered."

Covered Expenses	Regence BlueShield
Accidental injury care	100% up to $600/injury Deductible does not apply
Acupuncture	100% up to 12 visits/calendar year to approved provider (acupuncture for chemical dependency treatment provided separately)
Ambulance services	80%
Ambulatory surgical center	100% professional services 80% hospital/facility services
Blood bank	80%

Covered Expenses	Regence BlueShield
Chemical dependency treatment (including acupuncture and prescription drugs)	100% inpatient/outpatient Up to $12,000/2 calendar years (maximum subject to annual adjustment)
Diabetes care training	80%
Emergency care (in an emergency room)	80% after $25 copay/visit (waived if directly admitted)
Growth hormones	90% when preauthorized up to $25,000/calendar year
Home health care	90% up to 130 visits/calendar year
Home phototherapy (for newborn)	100%
Hospice care	90% (6-month maximum with up to 14 days inpatient care)
Hospital/facility services	80%
Infertility treatment (certain services only)	100% professional services 80% hospital/facility services
Injury to teeth	100% dentist/denturist services up to $600/injury
Infusion therapy	90%
Lab, x-ray and other diagnostic testing	100% professional services 80% hospital/facility services
Maternity and women's health care	100% professional services 80% hospital/facility services
Medical equipment	80%
Mental health care	100% professional services, 80% hospital/facility services for inpatient up to 8 days/calendar year 50% for outpatient up to 12 visits/calendar year
Neurodevelopmental therapy for covered family members age 6 and under	80% up to $2,000 annual benefit maximum
Newborn care (up to at least 3 weeks as mandated by state law)	100% professional services 80% hospital/facility services
Occupational injury	100% for LEOFF 1 only
Professional services	100% in an office, home, hospital or skilled nursing facility and for surgery 100% lab and x-ray
Prostheses and orthotics	80%
Phenylketonuria (PKU) formula	100%
Preadmission testing	100% professional services 80% hospital/facility services
Prescription drugs – up to 34-day supply through participating pharmacies	100% after $7 copay/prescription for generic 100% after $12 copay/prescription for brand-name 100% after $27 copay/prescription for non-formulary Copays do not apply against the deductible or out-of-pocket maximum

Covered Expenses	Regence BlueShield
Prescription drugs - up to 90-day supply through mail order	100% after $14 copay/prescription for generic 100% after $24 copay/prescription for brand-name 100% after $54 copay/prescription for non-formulary Copays do not apply against the deductible or out-of-pocket maximum
Preventive care (such as routine exams and immunizations)	100%
Radiation therapy and chemotherapy	100% professional services 80% hospital/facility services
Reconstructive services (including benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plan for more information)	100% professional services 80% hospital/facility services
Rehabilitative services	100% professional services and hospital/facility services for inpatient up to $50,000/condition 80% for outpatient up to $2,000/calendar year
Skilled nursing facility	80% up to 90 days/calendar year when preauthorized
Smoking cessation progam	75% up to $500 lifetime maximum
Spinal manipulation	100%
Sterilization procedures	100% professional services 80% hospital/facility services
Temporomandibular joint (TMJ) disorders	Not covered
Transplants (certain transplants/services only)	100% professional 80% hospital/facility services and travel expenses Donor organ procurement costs up to $50,000/transplant; travel expenses up to $2,500/transplant $250,000 lifetime maximum
Urgent care	Covered at various levels; call plan for details
Vision care – exams	100% for 1 exam/calendar year Deductible does not apply
Vision care – lenses	Up to 2 lenses/calendar year: ● $20/single vision lens ● $30/bifocal lens ● $40/trifocal lens ● $65/lenticular or aphakic lens (external lens requiring a frame) Deductible does not apply
Vision care – frames	$30 for 1 pair of frames/2 calendar years beginning with the initial date of service Deductible does not apply
Vision care – contact lenses (instead of glasses)	If medically necessary, up to $100/lens for aphakia or for vision correctable to 20/70 or better only by use of contact lenses If elected, up to $20/lens Deductible does not apply

► Accidental Injury Care

If benefits do not cover in full the treatment of accidental injury, this benefit pays in full up to a maximum of $600 per occurrence (deductible does not apply). Treatment must begin within 30 days of the accident and is covered to a maximum of 12 consecutive months after the date of injury. If treatment continues beyond 12 months or the $600 maximum, the plan pays benefits as any other illness or injury.

► Ambulance Services

The services of a recognized licensed ambulance company are covered if other transportation would endanger your health and the purpose is not for personal reasons or convenience. Benefits include licensed air ambulance, when medically necessary (as for all services and supplies, as determined by Regence BlueShield), to the nearest hospital equipped to provide the necessary treatment.

► Chemical Dependency Treatment

The services and supplies of an approved program are covered, including supportive services. Any benefits paid during the current or previous calendar year under this or a prior Regence BlueShield plan count toward the chemical dependency treatment benefit maximum of $12,000 in two calendar years. Expenses for:

- Acupuncture related to chemical dependency treatment count toward the maximum, but not the regular 12 visit/calendar year acupuncture benefit
- Medically necessary detoxification are covered as emergency care and do not count toward the maximum benefit if you're not enrolled in other chemical dependency treatment
- Drugs prescribed and dispensed through an approved chemical dependency treatment facility are covered and count toward the maximum benefit.

Except for medically necessary detoxification, the program must submit treatment notice at least 10 days before treatment begins, whenever reasonably possible. When you're under court order to undergo chemical dependency assessment (or in other situations pending legal actions related to chemical dependency), Regence BlueShield reserves the right to require you, at your expense, to provide a chemical dependency treatment plan and initial chemical dependency assessment performed by a qualified counselor employed by an approved program at least 10 days before treatment begins.

(For benefit, "medically necessary" is defined by "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II," published in 1996 by the American Society of Addiction Medicine.)

Chemical dependency benefits exclude:

- Alcoholics Anonymous or similar chemical dependency programs
- Emergency service patrol
- Information or referral services
- Information schools
- Long-term care or custodial care
- Tobacco cessation programs or supplies (except as described under "Smoking Cessation").

No other chemical dependency benefits are provided under this plan, except as described above for detoxification.

► Diabetes Care Training

Outpatient diabetes self-management training and education, including nutritional therapy, is covered if recommended by an approved provider with expertise in diabetes.

► Emergency Care

A medical emergency is defined as the sudden onset of a condition or exacerbation of an existing condition requiring medically necessary care to safeguard your life or limb immediately after onset. To determine benefits,

Regence BlueShield considers symptoms of the condition and actions that would have been taken by a prudent person under such circumstances.

Conditions that might require emergency care include, but are not limited to:
- An apparent heart attack (chest pain, sweating, nausea)
- Bleeding that will not stop
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion (especially after a head injury).

In the event of a medical emergency, you may receive services from any provider, including those not normally covered under the plan.

For emergency care from a provider not normally covered, treatment is:
- Covered for 24 hours or the time reasonably required to come under the care of a participating provider
- Based on the provider's actual charges for services when reasonable and not increased because of plan coverage.

► Growth Hormones

Services and supplies are covered for growth hormone when performed and billed by an approved infusion therapy, as described below:
- For children with:
  - Growth hormone deficiency
  - Neonatal hypoglycemia associated with growth hormone deficiency
  - Prader-Willi syndrome
  - Pre-transplant chronic renal insufficiency
  - Turner's syndrome
  - Other conditions determined by Regence BlueShield to be a covered benefit since this plan was issued
- For adults with growth hormone deficiency as a result of:
  - Hypothalamic or pituitary disease due to destructive lesion of the pituitary or surrounding area as a result of treatment or surgery
  - Other conditions determined by Regence BlueShield to be covered.

Growth hormone treatment of these conditions is covered when authorized by Regence BlueShield in advance. Benefits are provided to a maximum of $25,000 per calendar year; no other benefits for growth hormone are provided under this plan.

► Home Health Care

The services and supplies of an approved home health care agency are covered in your home for treatment of an illness or injury if you meet all of these criteria:
- You're homebound – which means that leaving the home could be harmful, involving a considerable and taxing effort – and unable to use transportation without assistance
- Your condition is serious enough to require confinement in a hospital or skilled nursing facility in the absence of home health services
- Your provider establishes or approves and reviews at least every 60 days a written treatment plan specifying home health services and supplies (plan must be approved by Regence BlueShield).

Home health care benefits may be extended beyond the 130-visit per year maximum if you apply to Regence BlueShield and the plan determines continued treatment is medically necessary. Any home health care expenses that qualify under this benefit and under another benefit of this plan will be covered only under the benefit Regence BlueShield determines most appropriate.

Benefits are limited to the following services in your home and must be provided by employees of and billed by the home health agency:

- Home health aide services, including such care as:
  - Ambulation and exercise
  - Assistance with self-administered medications
  - Completing appropriate records
  - Personal care or household services that are needed to achieve the medically desired results
  - Reporting changes in your condition and needs
- Medical supplies dispensed by the home health care agency that would have been provided on an inpatient basis
- Skilled services by approved providers, including:
  - Medical social services
  - Intermittent skilled nursing services
  - Nutritional guidance
  - Physical, occupational, respiratory and speech therapy services.

For professional services, home medical equipment and infusion therapy see those sections.

Home health care benefits exclude:

- Custodial or maintenance care
- Financial or legal counseling services
- Food, clothing, housing or transportation (except as described)
- Homemaker or housekeeping services (except as described)
- Hourly care services
- Services normally provided under a hospice program
- Services of volunteers, household members, family or friends
- Services or supplies not specified as a covered benefit in the written treatment plan, or limited or excluded under the plan
- Services to other family members
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.

► Home Phototherapy

Services and supplies by an approved phototherapy provider are covered for newborn hyperbilirubinemia (newborn jaundice).

► Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. Services of an approved hospice are covered for medically necessary treatment or palliative care (relief of pain and other symptoms) if:

- You're terminally ill
- Your provider establishes or approves and reviews at least every 60 days a written treatment plan specifying hospice services and supplies (plan must be approved by Regence BlueShield).

Hospice benefits are limited to six months, but the benefits may be extended beyond the six-month maximum if you apply to Regence BlueShield and the plan determines continued treatment is medically necessary. Any hospice care expenses that qualify under this benefit and under another benefit of this plan will be covered only under the benefit Regence BlueShield determines most appropriate.

Home Care. Benefits are limited to the following services in your home and must be provided by employees of and billed by the hospice:

- Home health aide services (limited to visits of four or more hours when skilled care is required by an RN, LPN or home health aide, up to a combined total of 120 hours for nursing services and home health aide services), including such care as:
  - Ambulation and exercise
  - Assistance with self-administered medications
  - Completing appropriate records
  - Personal care or household services needed to achieve the medically desired results
  - Reporting changes in your condition and needs
- Medical supplies dispensed by the hospice that would have been provided on an inpatient basis
- Respite care to provide temporary relief to family members or friends providing care (limited to four or more hours a day when no skilled care is required up to a combined total of 120 per three-month period)
- Skilled services by qualified providers, including:
  - Medical social services
  - Nursing services (limited to visits of four or more hours when skilled care is required by an RN, LPN or home health aide, up to a combined total of 120 hours for nursing services and home health aide services)
  - Nutritional guidance
  - Physical, occupational, respiratory and speech therapy services.

Inpatient Care. When you're confined as an inpatient in an approved hospice that isn't a participating hospital or skilled nursing facility, the same benefits that are available in your home are covered, in addition to a semiprivate room. The services must be provided by employees of and billed by the participating hospice. This inpatient benefit is limited to 14 days during the six-month hospice benefit period.

Exclusions. Hospice benefits exclude:

- Custodial or maintenance care (except benefits for palliative care to a terminally ill patient, subject to the limits described)
- Financial or legal counseling services
- Food, clothing, housing or transportation (except as described)
- Homemaker or housekeeping services (except as described)
- Services of volunteers, household members, family or friends
- Services or supplies not specified as a covered benefit in the written treatment plan, or limited or excluded under the plan
- Services to other family members
- Spiritual or bereavement counseling
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.

► Hospital/Facility Services

Inpatient and outpatient hospital services of a service area or out-of-area hospital are covered for injury and illness (services of staff physicians billed by the hospital are paid under the professional services benefit). Room and board coverage is limited to the hospital's average semiprivate room rate.

You're responsible for the emergency room copay for each hospital emergency room visit unless you're directly admitted to the hospital.

Hospitalization for Dentistry. The plan covers hospitalization for dental services (including anesthesia) if medically necessary to safeguard your health. Benefits are provided up to $1,000 per calendar year and cover:

- Inpatient and outpatient services of an approved hospital
- Services in an approved ambulatory surgical center
- Services of an approved physician.

The plan doesn't cover:
- Charges of a dentist
- Hospitalization for malocclusions or other abnormalities of the jaw, except when specified otherwise
- Hospitalization for myofascial pain syndrome or any related appliances.

► Infertility Treatment

Medical treatment is provided for infertility the same as any other condition.

The plan doesn't cover:
- Artificial insemination
- Embryo transfer procedures
- In vitro fertilization
- Infertility drugs (such as but not limited to Clomid, Pergonal or Serophene)
- Other artificial means of conception; however, a resulting pregnancy is covered under the maternity benefits as applicable.

► Injury to Teeth

Services of a licensed dentist or denturist and related hospital expenses are covered for repair of accidental injury to sound, natural teeth and injuries caused by biting or chewing; dental implants are not covered. Treatment must begin within 30 days of the injury and is covered to 12 consecutive months after the injury and $600 per occurrence.

This benefit is supplemental to your dental plan coverage.

Charges for repair of teeth do not count toward the out-of-pocket maximum.

► Infusion Therapy

Services and supplies for infusion therapy are covered when performed and billed by an approved provider. Drugs and supplies used in conjunction with the therapy are covered only under this benefit.

► Lab, X-ray and Other Diagnostic Testing

Lab and x-ray services are covered.

Screening and diagnostic mammography services are covered if recommended by the following participating providers:
- Physician
- Advanced RN practitioner
- Licensed physician assistant.

► Maternity and Women's Health Care

Maternity services are treated the same as any other illness or injury. Covered maternity care expenses include:
- Complications from pregnancy (including but not limited to diabetes if onset is after conception, fetal distress and toxemia)
- Normal or cesarean delivery
- Prenatal and postnatal treatment of pregnancy (including false labor)
- Prenatal screening and diagnosis of congenital disorders (when medically necessary in accordance with Washington State Board of Health standards)
- Voluntary termination of pregnancy.

For emergency maternity care, you may see any provider. If you receive emergency care from a non-participating provider outside the service area, contact Regence BlueShield within 48 hours.

Under federal law, benefits for any hospital length of stay due to childbirth for the mother or newborn cannot be limited to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the provider, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours. If you receive inpatient maternity care from a non-participating provider outside the service area, contact Regence BlueShield within 48 hours.

These maternity benefits are not available for covered children. Complications of pregnancy are covered as any other condition.

Women's health care services are covered if performed by a participating provider, approved advanced RN practitioner specializing in women's health and midwifery or approved provider's assistant. Covered services include (in addition to the maternity care already described):
- General exams
- Gynecological care
- Preventive care.

► Medical Equipment

Home Medical Equipment. Home medical equipment to treat a medical condition, if generally not useful in the absence of the condition and can withstand repeated use, is covered under this benefit. (Equipment primarily for preventing illness or injury, designed to assist a person caring for the patient or generally useful in the absence of the medical condition is not covered.)

Home medical equipment must be ordered while coverage is in effect and delivered within 30 days after coverage terminates. The fact an item may serve a useful medical purpose does not ensure it's covered. Regence BlueShield may elect to provide benefits for a less costly alternative item. Rental (or purchase if approved by Regence BlueShield) of home medical equipment for therapeutic use includes:
- Crutches
- Diabetic equipment (when medically necessary), including:
  - Blood glucose monitors
  - Insulin infusion devices
  - Insulin pumps and accessories
- Equipment for the administration of oxygen
- Kidney dialysis equipment
- Standard hospital beds
- Wheelchairs.

Repair or replacement of home medical equipment is also covered if necessary due to normal use or growth of a child.

The following items are not covered:
- Adjustable beds
- Air conditioners or dehumidifiers
- Arch supports or casting for arch supports or corrective shoes
- Enuresis (bed wetting) training equipment
- Exercise equipment or weights
- Eyeglasses (see "Vision Care")
- Hearing aids
- Heating pads
- Home birthing tubs
- Keyboard communication devices

- Motorized equipment
- Orthopedic chairs
- Personal hygiene items
- Whirlpool baths.

Special Equipment and Supplies. Covered special equipment and supplies include:
- Casts
- Catheters
- Dressings for wounds, cancer, burns or ulcers (as with all services and supplies, must be medically necessary)
- FDA-approved contraceptive supplies, devices and implants requiring a prescription
- Orthotics (see "Prostheses and Orthotics")
- Ostomy bags and supplies
- Prosthetics (covered for functional reasons when replacing a missing body part, but not for cosmetic reasons; see "Prostheses and Orthotics;" also see "Reconstructive Services" for details about prostheses used in mastectomy-related reconstructive breast surgery)
- Surgical appliances
- Syringes and needles for allergy injections (syringes and needles for other injectables are covered under "Prescription Drugs").

► Mental Health Care

Inpatient. Inpatient mental health care is covered to a maximum of eight days per calendar year when you're confined in an approved hospital or psychiatric hospital, state mental hospital or a licensed community mental health agency with an inpatient facility.

Partial hospital day treatment at an approved facility counts toward the eight-day inpatient maximum per calendar year; two partial days count as one inpatient day, regardless of partial day duration.

Outpatient. Outpatient mental health care is covered at 50% of the allowed amount of the plan for a maximum of 12 visits per calendar year when received from an approved provider:
- Licensed community mental health agency
- Marriage and family therapist (marriage and family counseling not covered)
- Masters of social work
- Mental health counselor
- Psychologist.

Covered outpatient services include (but are not limited to) diagnostic testing and treatment for mental disorders:
- Related to a learning disability
- Related to a self-inflicted injury or attempted suicide
- Related to an eating disorder (anorexia nervosa, bulimia or any similar condition is covered only for counseling under this benefit)
- With a congenital or physical basis.

Coinsurance paid for outpatient care doesn't apply to your out-of-pocket maximum.

(You may also receive limited mental health care benefits at no cost through King County's Making Life Easier Program by calling toll-free 1-888-874-7290.)

► Neurodevelopmental Therapy

Neurodevelopmental therapy is covered to treat neurodevelopmental delay (a delay in normal development that is not a documented illness or injury) when performed to restore and improve function for children six and younger. This benefit includes maintenance service if significant deterioration of the child's condition would result without the service.

Coverage includes:
- Inpatient hospital and skilled nursing facility care for an inpatient neurodevelopmental therapy admission when care cannot safely be provided as an outpatient; hospital services must be received in a hospital approved for rehabilitative care
- Services of an approved provider for physical, speech and occupational therapy in the office, home or a hospital outpatient facility.

Benefits are limited to $2,000 per calendar year for all neurodevelopmental therapy services combined and:
- All treatment must be provided in Regence BlueShield-approved hospitals
- All professional services must be performed by approved providers and
- A covered child is not eligible for services to treat the same condition under both this and the rehabilitative services benefit.

The provider must request pre-approval and Regence BlueShield must periodically review a written treatment plan specifically describing the neurodevelopmental services to be provided.

Coinsurance doesn't apply to your out-of-pocket maximum.

Neurodevelopmental therapy benefits exclude:
- Chemical dependency rehabilitative treatment
- Custodial care
- Gym or swim therapy
- Maintenance therapy (except as specified)
- Mental health care
- Nonmedical self-help, recreational, educational or vocational therapy.

► Newborn Care

This plan covers newborns for routine care, illness, accidental injury or physical disability (including congenital anomalies) under the mother's coverage for the first 21 days, as required by Washington State law. To continue the newborn's coverage after 21 days, the newborn must be eligible and enrolled by the deadline as described in the Important Facts booklet.

When the spouse/domestic is not eligible for the maternity benefit, a newborn receives the professional services and hospital benefits of this plan for routine care while hospitalized for the first 72 hours following birth.

Services and supplies by an approved home phototherapy provider are provided for newborn hyperbilirubinemia (newborn jaundice).

► Occupational Injury for LEOFF 1 Members Only

Services and supplies to treat occupational injury are covered only if you're legally exempt from and not covered by state industrial insurance, workers' compensation or similar coverage. The benefit is paid at 100% of the allowed amount for participating providers and 100% of the billed charges for non-participating providers; it is not subject to the annual deductible.

► Phenylketonuria (PKU) Formula

The plan covers medical dietary formula that treats phenylketonuria.

► Preadmission Testing

Services of an approved physician and an approved hospital are covered for outpatient preadmission testing for surgery at the hospital where you will be treated if you're admitted within 48 hours after testing begins.

► Prescription Drugs

Drugs requiring a prescription by federal or state law are covered when dispensed by an approved pharmacy or mail order supplier to treat a covered condition; these restrictions apply:

- The drug must be prescribed by a covered provider acting within the scope of his/her license
- The drug may require preauthorization by Regence BlueShield before it's covered (approved pharmacies have lists of drugs requiring preauthorization)
- Certain drugs may be limited to a lesser supply than indicated on your prescription or as determined by Regence BlueShield (approved pharmacies have lists of these drugs)
- Drugs related to transplants are covered under this benefit (claims for those drugs count toward the transplant benefit maximum)
- Regence BlueShield may require you to obtain all prescriptions from a single approved pharmacy
- Any drug purchased outside the United States must have an equivalent to an FDA-approved prescription drug and must be either:
  - Associated with a medical emergency while you're traveling (when submitting your claim, you're responsible for notifying Regence BlueShield that the drug was required for a medical emergency) or
  - Prescribed when you're living outside the United States and purchased in the country where you're residing, except for a medical emergency (when submitting your claim, you're responsible for notifying Regence BlueShield that you live outside the United States).

FDA-approved drugs used for off-label indications are covered only if recognized as effective for treatment in a standard reference compendium, in most relevant peer-reviewed medical literature or by the federal Secretary of Health and Human Services. Drugs the FDA has determined to be contra-indicated are not covered.

Other items covered under this benefit and requiring a prescription include:

- Diabetic supplies, including insulin and insulin syringes
- Legend vitamins for prenatal care
- Oral contraceptive drugs (provided for a single copay per prepackaged monthly cycle; a maximum of three prepackaged monthly cycles may be purchased at once)
- Smoking cessation prescription medicines (limited to 90-day lifetime maximum supply).

Copays for prescriptions do not apply to your annual deductible or annual out-of-pocket maximums.

Copays are lowest when you use generic drugs included in the formulary (list of generic and brand-name drugs maintained by Regence BlueShield) and highest when you use brand-name drugs with a generic equivalent or drugs not included in the formulary.

Prescription drugs are not subject to the coordination of benefit provision (see "Coordination of Benefits Between Plans").

Exclusions. The following are not covered under the prescription benefit:

- Any drugs or items obtained from an approved pharmacy when you fail to present your ID card
- Any items limited or excluded by this plan
- Appetite suppressants or drugs for weight loss
- Drugs or medications for cosmetic purposes
- Drugs dispensed by a non-approved pharmacy, except when specifically provided for emergencies or outside the service area
- Growth hormone, except as specified in the growth hormone benefit of this plan
- Injectable drugs, except as specified in the professional benefit of this plan
- Inside the United States, any prescription drug not approved by the FDA, including compounded products with active ingredient(s) that haven't been approved by the FDA
- Oral progesterone compounded products
- Over-the-counter medications or any prescription with the same active ingredients as an over-the-counter product

- Replacement prescriptions resulting from loss, theft or breakage

Using a Participating Pharmacy. You may order up to a 34-day supply from a participating retail pharmacy (certain maintenance drugs for chronic conditions listed in Regence BlueShield's Value-Added List are limited to 100 tablets/capsules or a 34-day supply, whichever is greater). To order:
- Choose a participating pharmacy (contact Regence BlueShield for a list of participating pharmacies or to find one near you; see the Resource Directory booklet)
- Show your Regence BlueShield ID card to the participating pharmacist each time you want a prescription filled or refilled
- Pay the copay for each covered new prescription or refill.

There are no claim forms to submit; the participating pharmacy bills the plan directly.

Mail Order Service. To use the mail order service, send an order form with your copay directly to the address on the form each time you order a new prescription. You must include your physician's written prescription with your order form and payment.

If you use the mail order service:
- Drugs requiring continuous refrigeration may not be available by mail order
- Certain drugs, including but not limited to antidepressants, narcotics and certain other medications may be limited to less than a 90-day supply
- You pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply.

Your Right to Safe and Effective Pharmacy Services. Regence BlueShield as well as state and federal laws establish standards to assure safe, effective pharmacy services and guarantee your right to know what drugs are covered under this plan and any limits. If you would like more information about the plan's drug coverage policies or if you have any question or concern, contact Regence BlueShield (see the Resource Directory booklet).

If you would like to know more about your rights under the law, or if you believe any of these prescription benefits may not conform to the plan or your rights, contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, call the State Department of Health at 360-236-4825.

► Preventive Care

The following preventive care services are covered on an outpatient basis as any other illness or condition, including women's health care services, and must be recommended by your approved provider:
- Office calls as well as related lab and x-ray services for cancer screening (mammograms are covered as a regular plan benefit)
- Pediatric and adult immunizations (immunizations for travel are not covered)
- Routine pediatric and adult physical exams
- Routine well-baby care from birth.

► Professional Services

The plan covers diagnosis and treatment of illness, accidental injury and physical disability, including:
- Injectable drugs
- Medical care in the provider's office or hospital
- Outpatient x-ray and lab
- Provider services for surgery, anesthesia, inpatient and emergency room visits
- Second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training).

► Prostheses and Orthotics

Benefits are provided under the plan for the purchase of:
- Braces
- Splints
- Orthopedic appliances
- Other orthotic supplies
- Prostheses to replace missing body parts for functional but not cosmetic reasons (except medically necessary external and internal breast prostheses after a mastectomy).

Prostheses and orthotics must be ordered while coverage is in effect and delivered within 30 days after coverage terminates. Regence BlueShield may elect to provide benefits for a less costly item.

► Radiation Therapy and Chemotherapy

Radiation therapy and chemotherapy are covered. (Respiratory therapy is covered under the home health care, hospice care and hospital care benefits.)

► Reconstructive Services

The plan covers reconstructive surgery:
- When related to an illness or injury
- For congenital anomalies
- For reconstructive breast surgery and associated procedures, following a mastectomy (regardless of when the mastectomy was performed) as determined in consultation with the patient and attending physician including:
  - Reconstruction of the breast on which the mastectomy was performed
  - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

► Rehabilitative Services

The benefits described below are for rehabilitative care when medically necessary to restore and improve function previously normal but lost following a documented illness (for example, stroke, viral infection or bacterial infection – prenatal, perinatal, childhood, adolescence or adulthood) or injury (prenatal, perinatal, childhood, adolescence or adulthood), including function lost as a result of congenital anomalies. Care must be provided by a participating provider.

The plan covers:
- Inpatient hospital and skilled nursing facility expenses for physical, speech or occupational therapy to a maximum of $50,000 per condition. Services must be received in a hospital or skilled nursing facility approved by Regence BlueShield for rehabilitative services, and treatment must occur within three years from the date of your first hospital or skilled nursing facility rehabilitative care admission. At least every 60 days, your provider must submit for approval and review a written treatment plan specifying rehabilitative services before treatment is received, except in emergencies.
- Physical, occupational or speech therapy in the office, home or hospital outpatient facility is covered to $2,000 per calendar year if performed by an approved provider (for physical, occupational and speech therapy only) or a hospital approved for rehabilitative care.

Charges for rehabilitative services do not contribute to the out-of-pocket maximum.

If you have a rehabilitative care admission and did not exhaust your $50,000 inpatient maximum, you may apply to Regence BlueShield for additional outpatient benefits beyond the $2,000 limit. Limited extensions will be granted, up to the balance of your unused inpatient benefit, if Regence BlueShield determines the services are medically necessary.

You're not eligible for the neurodevelopmental therapy benefit if you receive the same services for the same condition under this benefit.

No benefits are provided for:
- Chemical dependency rehabilitative treatment
- Custodial care
- Gym or swim therapy
- Learning disabilities or developmental delay
- Maintenance therapy (treatment to prevent disease, promote health or prolong and enhance life, or maintain/prevent deterioration of a chronic condition; once the maximum therapeutic benefit is achieved for a given condition, any additional therapy is considered to be maintenance therapy)
- Mental health care
- Non-medical self-help
- Recreational, educational or vocational therapy
- Treatment not prescribed by a participating provider.

► Skilled Nursing Facility

Inpatient services and supplies of an approved skilled nursing facility are covered for illness, accidental injury or physical disability, limited to 90 days per calendar year. Room and board is limited to the facility's average semiprivate room rate. Your approved physician must request Regence BlueShield approval and periodically review a written treatment plan specifically describing services to be provided. Custodial care is not covered.

The skilled nursing facility benefit is subject to these provisions:
- The patient must have been an inpatient in a participating hospital for three or more consecutive days for treatment of an illness, injury or physical disability
- The patient must have been admitted as an inpatient in an approved skilled nursing facility within 14 days after discharge from the hospital for treatment of the same condition
- The participating physician must certify that confinement that skilled nursing facility confinement is necessary for continued treatment of the condition for which the patient was hospitalized.

► Smoking Cessation

Services of an approved smoking cessation program are covered to a lifetime maximum of $500. To receive benefits for smoking cessation, you must complete the full course of treatment.

This benefit does not cover:
- Acupuncture
- Books or tapes
- Hypnotherapy unless performed by an approved provider
- Inpatient services
- Over-the-counter drugs or prescription drugs prescribed by your covered provider to ease nicotine withdrawal (however, drugs prescribed to ease nicotine withdrawal are covered under the prescription drug benefit)
- Vitamins, minerals or other supplements.

This benefit is not subject to the annual out-of-pocket maximum.

► Spinal Manipulation

The plan covers spinal manipulation by an approved provider if the service is within the lawful scope of the provider's license.

► Sterilization Procedures

Sterilization procedures are covered, but not reversals of these procedures.

► Transplants

Benefits for medically necessary services and supplies related to all transplants are provided to a combined lifetime maximum of $250,000, as determined by Regence BlueShield. A transplant recipient covered under this plan is eligible for these transplants, subject to certain conditions and limits:

- Cornea
- Heart
- Heart/lung (combined)
- Hematopoietic stem cell support; donor stem cells can be collected from either the bone marrow or the peripheral blood; hematopoietic stem cell support may involve autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor), or umbilical cord blood (covered only for certain conditions; contact Regence BlueShield for details)
- Islet cell
- Kidney
- Kidney/pancreas (combined)
- Lungs (single/bilateral/lobar)
- Liver
- Pancreas
- Small bowel
- Small bowel/liver/multivisceral
- Other transplants determined by Regence BlueShield to be covered since this plan was issued (contact Regence BlueShield for the current list of covered transplants; see the Resource Directory booklet).

Benefits for all transplants must be preauthorized by Regence BlueShield, with approval based on:

- Recipient's medical condition
- Provider qualifications
- Appropriate medical indications for the transplant
- Proven medical procedures for the type of condition.

All transplants must be provided in a facility approved by Regence BlueShield. If a transplant is not successful, only one retransplant is covered, subject to the benefit limits specified in the "Summary of Covered expenses."

The plan does not cover:

- Donor or procurement services/costs incurred outside the United States (unless approved by Regence BlueShield) or when available through other group coverage
- Investigational procedures
- Lodging, food, or transportation costs, unless otherwise specified under this plan
- Nonhuman, artificial or mechanical transplants
- Services in a facility not approved by Regence BlueShield
- Stem cell support or high-dose chemotherapy associated with stem cell support, except as specified
- Transplants when government funding of any kind is provided or when the recipient is not covered under this plan.

Donor Benefits. Donor organ procurement benefits are limited to medically necessary procurement costs as determined by Regence BlueShield, to a maximum of $50,000 per transplant. Donor benefits are charged against the recipient's benefit limits.

Travel Expenses. Travel and lodging expenses for you and your family are covered when you're required by Regence BlueShield to travel 75 miles or more from your residence to the facility where the transplant is received for medically necessary services related to an approved transplant. Benefits are paid at the level specified for participating hospitals to a maximum of $2,500 per transplant episode requiring travel and must be preapproved by Regence BlueShield.

► Urgent Care

If you need urgent care for conditions that are not life threatening but require immediate medical attention, call your provider's office for assistance (after office hours, call and leave your name and number; the provider on call will call you back). Depending on your situation, the provider may give instructions over the phone, asking you to come into the office or advising you to go to the nearest emergency room.

Conditions that might require urgent care include, but are not limited to:
- Ear infections
- High fevers
- Minor burns.

► Vision Care

Services of an approved optical provider, physician or optometrist are covered in full for one routine eye exam per calendar year to determine the need for a new or changed prescription for corrective lenses. Fittings for contact lenses are not covered.

Lenses and frames are covered when prescribed by an approved optical provider, physician or optometrist to correct a refractive error. For lenses and frames from an approved optical provider, Regence BlueShield pays the provider directly; for lenses and frames obtained from any other optical provider, you're reimbursed (see "Summary of Covered Expenses" for benefit amounts and limits).

This benefit is not subject to any deductible.

Expenses Not Covered

In addition to the exclusions and limits described in other sections of this booklet, the Regence BlueShield plan does not cover:
- Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program except:
  - For facilities included on the Regence BlueShield list of participating providers
  - As required by law, such as for medical emergency or for coverage provided by Medicaid
- Charges for services or supplies above the allowed amount, except for medical emergencies
- Charges there would be no obligation to pay in the absence of this plan
- Cochlear implants (unless preauthorized by Regence BlueShield)
- Conditions resulting from military service in the armed forces of any country or any act of war (declared or undeclared)
- Cosmetic surgery or supplies (including drugs), or treatment of any direct or indirect complications of such surgery except:
  - When related to an illness or injury
  - For congenital anomalies
  - For reconstructive breast surgery following mastectomies to the extent required under federal and state law as follows:
    - Reconstruction of the diseased breast
    - Reconstruction of the nondiseased breast to produce a symmetrical appearance
    - Prostheses and physical complications of all stages of a mastectomy, including lymphedemas
- Custodial care
- Dental services except as specified
- Dyslexia treatment except as specified
- Hearing aids or exams
- Hospitalization for conditions for which hospitalization is unusual, such as common colds or removal of small tumors

- In vitro fertilization, artificial insemination, embryo transfer, fertility drugs (such as Clomid, Pergonal or Serophene) or any other artificial means of conception; however, a resulting pregnancy is covered under the regular benefits of this plan, as applicable
- Injuries sustained while practicing for or competing in a professional or semiprofessional athletics contest ("semiprofessional" means an athletic activity for gain or pay that requires an unusually high skill level and a substantial time commitment from participants not engaged in the activity as a full-time occupation)
- Investigational services or supplies
- Marital or family counseling
- Mental disorder treatment for anorexia nervosa, bulimia or other eating disorders, except as specified under "Mental Health Care"
- Nursing services, except as specified; private duty nursing or hourly nursing charges are not covered
- Occupational injury or disease (including any arising from self-employment), except as specified
- Over-the-counter contraceptive supplies or devices
- Physical or psychiatric exams or psychological testing for obtaining or continuing employment, licensure, legal proceedings, insurance, school admission or sports activities, or conducted for medical research
- Services by a family member
- Services by King County or any of its employees or agents
- Services or supplies:
  - From government facilities outside the service area except as required by law, such as for emergency services
  - Not medically necessary (as defined in the Glossary booklet) to treat an illness or injury, unless otherwise listed as covered
  - Payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract or insurance issued to or available to the participant (whether or not application is made)
    - Any benefits provided by or advanced by Regence BlueShield contrary to this exclusion are solely to assist the participant
    - By paying those benefits, Regence BlueShield is not acting as a volunteer or waiving any right to reimbursement or subrogation (when no-fault insurance is available and benefit payments are not exhausted or denied for reasons other than medical treatment not being reasonable, necessary, related to the accident or incurred within three years of the accident, it is the participant's responsibility to pursue coverage through no-fault carrier to obtain the available limits of the no-fault coverage)
  - To the extent payable under Medicare Part A or B when, by law, this plan would not have been primary to Medicare if the participant had properly enrolled in Medicare when first eligible (regardless of whether the participant actually enrolled)
- Sexual dysfunction/impotence or transsexualism surgery or treatment
- Stem cell support or high-dose chemotherapy associated with stem cell support except as specified
- Treatment and any appliances used in connection with temporomandibular joint disorders, malocclusions or other abnormalities of the jaw
- Visual analysis, therapy or training; orthoptics
- Weight reduction, regardless of diagnosis, surgery (including reversals), treatment, programs or supplies.

Coordination of Benefits

► Coordination of Benefits Between Plans

If you or your dependents are covered under another health plan, Regence BlueShield coordinates benefits with the other plan so you receive up to but not more than 100% of covered expenses; the benefit paid by Regence BlueShield will not exceed the amount that would have been paid if no other plan was involved.

If another plan does not have a coordination of benefit (COB) provision, the other plan always pays first (the plan that pays first is called primary). Otherwise, the plan that covers the individual as an employee pays before the plan that covers the individual as a dependent.

The following guidelines determine what plan pays first for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- For a dependent child whose parents are divorced or legally separated, the plan that covers the child is determined in this order (unless there is a court decree establishing financial responsibility for the child's health care):
  - The plan of the parent with custody
  - The plan of the spouse of the parent with custody
  - The plan of the parent without custody
  - The plan of the spouse of the parent without custody.

If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.

If these provisions don't apply, the plan that has covered the participant longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer this COB provision.

► Coordination of Benefits With Medicare

If you keep working for the county after age 65 you may:

- Continue your medical coverage under a county plan and integrate the county plan with Medicare (the county plan would be primary)
- Discontinue your county medical coverage and enroll in Medicare; if you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see "COBRA" in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan (see the Resource Directory booklet).

Filing a Claim

► What to Do

If you receive care from a participating provider, the provider submits claims for you; if you receive a bill from a provider or facility, be sure they have billed Regence BlueShield. If you receive emergency services from a non-participating provider, it's your responsibility to submit a claim to Regence BlueShield or have the provider submit one for you.

When submitting any claim, you need to include your itemized bill. It should show:

- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service or date of purchase/rental of supplies
- Itemized charges from the provider for the services/supplies received.

You also need to provide:

- Your name (if you were not the patient)
- Your member ID number
- Group number (shown on your Regence BlueShield ID card and available from Benefits and Retirement Operations)
- Date, time, location and brief description of accident if treatment is the result of an accident.

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 16 months after the date of service or date of purchase/rental of supplies (nine months if the plan is terminated).

► If the Claim Is Approved

If the claim is approved and there's no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

► If the Claim Is Denied

If the claim is denied, you're notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that Regence BlueShield reviewed in making the determination.

If You Have a Problem

This is a brief summary of the steps and timeframes for filing a complaint or appealing a denied claim for reasons other than eligibility. When a claim is denied for eligibility reasons, follow the steps described in the "Claims Denied Due to Eligibility."

Washington State's "Patient Bill of Rights" law requires Regence BlueShield to provide this and other information about your rights when you first enroll, annually and upon request. If you have any questions or want more details, contact Regence BlueShield (see the Resource Directory booklet).

► First Step Complaint/Appeal

What You Do. To file a complaint or appeal, you or someone representing you must contact Regence BlueShield in writing or verbally within 180 days of receiving the written notice from Regence BlueShield prompting your complaint/appeal (for example, an explanation of benefits or letter denying a preauthorization request). Explain why you're dissatisfied with Regence BlueShield's decision or action. You may provide written materials supporting your complaint/appeal. If you or your provider is asking Regence BlueShield to reconsider a previously denied preauthorization, your provider may be able to talk directly with a medical director.

What Regence BlueShield Does. A Regence BlueShield member service specialist with contract benefits, enrollment and claim processing expertise accepts and logs your complaint/appeal and notifies you of receipt within five days. The specialist, working as needed with a medical director and medical services, legal or communication departments, investigates your complaint/appeal, gathers facts and prepares a complaint/appeal package of detailed information. Based on that package, the specialist makes a decision, records it in writing and sends it to you within 30 days of first receiving your complaint/appeal.

The decision must be understandable, describe how you may appeal the decision and the timing required, list the people at Regence BlueShield who helped make the decision, state the facts and refer to support documents. After receiving the decision, you may ask Regence BlueShield to reconsider by requesting a second step internal appeal review (see "Second Step Internal Appeal Review").

If more information is required to complete your initial complaint/appeal request, Regence BlueShield informs you of the delay in writing within the initial 30 days and provides a form for you to give written consent to an

extension of up to 15 days. Regence continues processing your complaint/appeal whether or not you return the form, unless you withdraw your complaint/appeal.

► Second Step Internal Appeal Review

What You Do. You may file an appeal of your first step complaint/appeal decision. To do so, you or someone representing you must contact Regence BlueShield in writing or verbally within 180 days of receiving the written decision notice from Regence BlueShield. You may provide written materials supporting your appeal and present your appeal in person.

What Regence BlueShield Does. A Regence BlueShield appeal coordinator (registered nurse) accepts and logs your appeal and notifies you of its receipt within five days. The appeal coordinator investigates your appeal, gathers facts and prepares an appeal package of detailed information for review by a panel of Regence Blue Shield representatives new to the case and not involved in the first step complaint/appeal decision. The panel is made up of the appeal coordinator, member service specialist with contract benefits, enrollment and claims processing expertise, and a medical director. The panel works as needed with Regence BlueShield medical services, legal or communication departments and other resources (the medical director may confer with an independent physician with medical training related to your appeal).

Based upon the appeal package and its investigation, the panel makes a decision, records it in writing and sends it to you by certified mail within 30 days of first receiving your appeal or within:

- 20 days if it concerns an investigational medical procedure
- 14 days if it concerns a service your provider wants for you but needs approval from Regence BlueShield to perform.

The decision must be understandable, describe how you may request another appeal and the timing required, list the people at Regence BlueShield who helped make the decision, state the facts and refer to support documents. After receiving the appeal decision, you may ask Regence BlueShield to reconsider by requesting a third step external appeal review (see below).

► Third Step External Appeal Review

What You Do. You may file an appeal of your second step appeal decision. To do so, you or someone representing you must contact Regence BlueShield in writing or verbally within 180 days of receiving the written appeal decision notice from Regence BlueShield.

What Regence BlueShield Does. A Regence BlueShield appeal coordinator accepts and logs your appeal and notifies you of its receipt within five days. The appeal coordinator gathers all facts and supporting documents together with the second step appeal package and delivers it for review by an Independent Review Organization (IRO) within three days of receiving your request for an external appeal. The IRO is made up of physicians with medical training in the area of your appeal; they are not associated with Regence BlueShield, nor have they been involved in your first step complaint/appeal decision or second step internal appeal decision.

Based on the appeal package and its investigation, the IRO makes a decision, records it in writing and sends it to Regence BlueShield. Regence BlueShield notifies you by certified mail within 20 days of first receiving your third step appeal review request.

The Regence BlueShield notification must be understandable, describe the next appeal level (if any) and the timing required, list the independent physicians who made the decision, state the facts and refer to support documents.

► Optional Non-Binding Mediation

An optional step may be available if your appeal is denied at the third step. The third step external appeal notification describes non-binding mediation and how to request the non-binding mediation process.

If Regence BlueShield fails to respond within 30 days to your or your representative's written request to have an appeal heard in person, you may proceed as if your appeal has been rejected, including submitting such appeal to non-binding mediation.

► Expedited Appeal Process

For members who need a faster process because of a life-threatening medical condition, there is an expedited appeal process. If the expedited appeal process is warranted, second step internal review decisions and third step external review decisions are made within one working day or 72 hours, whichever is less, after receiving your expedited appeal request.

Non-binding mediation may also be a final, optional step in the expedited appeal process. Regence BlueShield advises you if non-binding mediation is an option for you if the third level expedited external appeal is denied.

► Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- 14 days for pre-service appeals (within 30 days if an extension is filed)
- 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice includes the plan provision behind the decision and advises you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after

receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Recovery of Payments

If you or a covered dependent is injured by another party who is legally liable, or if you are entitled to be compensated under the terms of any automobile uninsured or underinsured motorist coverage, the benefits of this plan will be available if you agree to cooperate with Regence BlueShield in its rights to recover benefit payments and you agree to reimburse Regence BlueShield for the amount it has paid according to contract provisions.

Release of Medical Information

As a condition of receiving benefits under this plan, you and your family members authorize:

- Any provider to disclose to the plan any requested medical information
- The plan to examine your medical records at the offices of any provider in accordance with state and federal law
- The plan to release to or obtain from any person or organization any information necessary to administer your benefits
- The plan to examine records that would verify eligibility.

Regence BlueShield will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under this plan ends, Regence BlueShield, in most cases, sends you a certificate of health coverage. Regence BlueShield also issues a certificate at your request within 24 months of when your coverage ends and automatically, when required by law.

The certificate provides important information about your length of coverage under the plan. Please verify accuracy when you receive the certificate and keep it in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

If you don't receive a certificate or misplace it, contact Regence BlueShield (see the Resource Directory booklet).

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay (if any) for these benefits.

You will not be able to convert to the conversion plan if you're eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to Regence BlueShield within 31 days after this medical coverage terminates. Evidence of insurability will not be required. You will not receive this application or information about conversion plan coverage unless you request it from Regence BlueShield (see the Resource Directory booklet for contact information).

Extension of Coverage

If this plan is canceled, Regence BlueShield will continue to cover any participants who are hospital inpatients on the cancellation date. Coverage ends when the first of the following events occurs:

- Six consecutive months expire
- Your hospital/facility inpatient care benefits under the plan are exhausted (no benefits renew January 1)
- You become covered under another group contract with Regence BlueShield
- You're enrolled under a contract with another company that provides hospital inpatient care
- You're discharged from the hospital/facility.

This extension does not apply to the newborn who is eligible for coverage only for the first 21 days following birth as specified in "Newborn Care," nor does it apply if you're eligible for COBRA continuation.

Maternity Extension. A covered employee or spouse/domestic partner who's pregnant when coverage ends is eligible for the plan's maternity benefits until 14 days following termination of pregnancy if he/she transfers directly to a Regence BlueShield conversion plan and continues coverage until termination of pregnancy.

Disability Extension. If you or any covered family member is totally disabled due to a covered condition and apply to Regence BlueShield within 30 days of when your coverage would normally end, your plan benefits will continue for treatment of the condition for a maximum of 12 months, until benefits are exhausted or until you're enrolled under another group plan, whichever occurs first. Proof of disability is required. (If you continue coverage through COBRA, you're not entitled to this disability extension.)

If you or a covered family member is pregnant and your expected or actual due date is within two weeks of when your coverage would normally end, the disability extension doesn't require written application. It extends from two weeks before anticipated delivery to six weeks after and may be longer if certified by a physician. The disability extension applies whether or not you or a covered family member transfer to an individual plan.

For the disability extension to apply, you or a covered family member must be unable, solely because of non-occupational illness or accidental injury, to:

- Engage in any occupation for which you're reasonably qualified by education, training, or experience
- Perform any work for compensation
- If not previously employed, engage in most of the normal activities of a person of like age and sex in good health.

Payment of Benefits

The medical benefits offered by this plan are insured by Regence BlueShield, meaning this is not a self-funded plan. Regence BlueShield is financially responsible for claim payments and other costs.

Regence BlueShield does not provide health care services. All health care services for covered benefits are provided by facilities and professionals who are neither employees nor agents of Regence BlueShield. The fact a provider is listed in a directory of Regence BlueShield participating providers does not mean the provider is Regence BlueShield's employee or agent. Providers are responsible for the quality of care they render.